Board Request - April 26-28 Full Board Meeting	Program Response	Provided:	Completed?
Annual statistics (incoming/acceptances/denials/types of denials)	**RESPONSE**: The program's website shows cumulative statistics but they are not broken down annually. Combined statistics, State and worksite statistics, and statistics on Total Benefits Paid by Facility are available. https://www.dol.gov/owcp/energy/ . If annual numbers for specific categories are needed the program can reconstruct them.	Website provided at meeting.	**Completed**
Typical case load per CE, time it takes to finish a case (Sokas)	**RESPONSE**: The Operating Plan is available here: <http://www.labornet.dol.gov/workplaceresources/policies/Strategic-Plan/2016-operating-plans/OWCP-FY16-Operating-Plan.pdf>. It shows the timeliness measures the program utilizes. The Operational Plan shows the measures in more detail, including timeliness and others, that are used on a daily basis in running the program. The program will provide the Operational Plan (with a watermark saying it is not releasable to the public.)	FY16 DEEOIC Operational Plan (Watermarked for Not For Public Disclosure)	**Completed**; on first nonreleasable disc
How much does it cost to administer the EEOICPA (Redlich)	**RESPONSE**: The program provided statistics from OMB.	OMB Budget Justification is posted: https://www.dol.gov/sites/default/files/documents/general/budget/2016/CBJ-2016-V2-06.pdf	**Completed**
Performance evaluation criteria – for the program and for individuals (Dement)	**RESPONSE**: The program provided the FY16 DEEOIC Operational plan for program performance; the FAB prototype standards; and an example of GS-12 CE performance standards.	FY16 DEEOIC Operational Plan (Watermarked for Not For Public Disclosure); FY16 FAB Claims Examiner Prototype Standards (Watermarked for Not For Public Disclosure); FY16 FAB Hearing Representative Prototype Standards (Watermarked for Not For Public Disclosure); FY16 District Office Claims Examiner Sample Standards (Watermarked for Not For Public Disclosure)	**Completed**
Accountability review manual	**RESPONSE**: The program provided the most recent accountability review manual, with a "not releasable" watermark.	Provided	**Completed.** On first nonreleasable disc.

OHQ – how was it developed and by whom (Sokas)	**RESPONSE**: The program provided a narrative explanation of the development of the OHQ, stating it is based loosely on the DOE former worker program questionnaire but also on other sources.	Provided	**Completed.**
Copies of audits and accountability reviews for CMCs (Markowitz)	**RESPONSE**: The CMC contract, like other contracts, is owned by OASAM (Office of the Assistant Secretary for Administration and Mangement). The program will have to get permission from OASAM, who will likely have to get permission from the contractor, before this information can be provided. The program has asked OASAM to begin this process, but the answer may be that providing it will not be	DEEOIC CMC SOW	*asking OASAM*
Can people see the original records that go into SEM?	**RESPONSE**: The program checked with the contractor on proprietary interests. These records can be requested on specific topics, though in general thousands and thousands of "original records" have been entered into SEM.		*asking contractor*
Was Ruttenbr database used in SEM data?	**RESPONSE**: No it was not.	Nothing to provide.	**Completed**
What percentage of cases change outcome from RD to FD	**RESPONSE**: The program provided an explanation of the adjudication process. There are many options for what can happen between a RD and a FD; explain the different options.	Provided.	**Completed.** On first nonreleasable disc.
Examples of FDs (referred to website decision database)	**RESPONSE**: The board was referred to the final decision database on the program's website.	Website provided at meeting.	**Completed**
Policy call notes	**RESPONSE**: Provided unredacted.	Provided	**Completed.** On first nonreleasable disc.
Dr. Schwartz' memo (Dr. Markowitz has this) and a particular letter from ANWAG behind the IOM report (or perhaps it was a presentation by Terrie Barrie and Dr. Manuta)(Dr. Markowitz)	**RESPONSE**: The presentation is posted on the Advisory Board's website.	Presentation posted on website.	**Completed**
Examples of a SOAF/referral packet for IH/CMC (referred to Jeff's presentation)(see Day 3 #5)	**RESPONSE**: An example was provided in the presentation materials by Jeff Kotsch.	Board materials are posted on the website.	**Completed**
Will Board have access to proprietary SEM? (Domina)	**RESPONSE**: The program has to coordinate with DOE on this request, and an inquiry has been made to begin the discussion.		*may request it for Mr. Griffon*
Public SEM user guide? (Griffon) (was referred to website)	**RESPONSE**: A referral to the program's website has been provided.	Website provided at meeting.	**Completed**
Data on at what stage claims are denied, before referred to IH or what (Cassano)	**RESPONSE**:		**Completed**
Number of cases on major diseases, % accepted and denied, to prioritize efforts (Redlich)(Tony asked for this is writing, see notes from follow-up call with Dr. Redlich)(Doug to provide)	**RESPONSE**: Information on beryllium disease will be provided per a discussion between Dr. Redlich and the program.	Dr. Redlich's data request has been provided.	**Completed**

Use CARES (?) database (DOE incident database) of site accidents to add to the SEM? (Vlieger)	**RESPONSE**: The program understands that Ms. Flieger has requested this from the DOE, who owns this database.		**Completed**
SEM scope of work; relation to Haz-Map, contract with Dr. Brown/ MOU with NLM	**RESPONSE**: Dr. Brown does not currently work directly for DOL or our SEM contractor. DOL also recently ended our MOU with HHS/NLM.	Nothing to provide.	**Completed**
Provide treating physicians with language guidance? (Boden)	**RESPONSE**: See the procedural manual for general information about what CE's should look for in medical reports (PM2-0800m Developing & Weighing Medical Evidence). This is posted on line and in the briefing materials from the April 2016 meeting.	Website provided at meeting.	**Completed**
How often are secops and referees used to show causation?	**RESPONSE**: The program provided the number of secops or referee opinions, using the claims tracking database.		**Completed.** On first nonreleasable disc.
How many new CBD claims per year (Redlich)(see Doug's list from call with Dr. Redlich)	**RESPONSE**: Provided.	Dr. Redlich's data request has been provided.	**Completed**
How does the program make presumptions (Rachel asked for help in creating more)	**RESPONSE**: A list of bulletins, circulars and procedure manual sections relevant to each of the four topic areas has been provided.	This was provided in the briefing materials and posted online.	**Completed**
Copies of the contract for IH services (QTC) (Markowitz)	**RESPONSE**: OASAM owns the contract. The program has begun the process of asking permission to share items, but may not receive a favorable response.	DEEOIC CCIH SOW	***asking OASAM***
Audit of secops from 2015 and annual AR findings (Markowitz)	**RESPONSE:** Provided.	2015 Internal CMC Audit Findings (previously made public through FOIA)	**Completed**
Accountability reviews (Markowitz)	**RESPONSE**: The program provided FY2015 findings.		**Completed.** On first nonreleasable disc.
Copy of CMC manual	**RESPONSE**: OASAM owns the contract. The program has begun the process of asking permission to share items, but may not receive a favorable response.		***asking OASAM***
Copies of redacted CMC reports (Sokas)	**RESPONSE**: Provided three examples.		**Completed.** On first nonreleasable disc.

Percent of cases approved as a result of CMC reports	**RESPONSE**: The program cannot run a report that will show this information, because they cannot tell through a report how the results of a CMC may have been used in different cases. In order for them to know whether there was a direct correlation between an approval and a particular CMC report, the program would have to manually review individual cases.		**Completed**
Drafts of revised materials (Sokas)	**RESPONSE**: As indicated at the meeting the program will provide OHQ updates to the board.	Updated will be provided when available	**Completed**
Education level of the claims examiners (Friedman-Jimenez)	**RESPONSE**: The program will provide a sample job posting for a claims examiner position, to show what the program is looking for in terms of qualifications.	Sample FAB Claims Examiner Job Announcement; Sample District Office Claims Examiner Job Announcement	**Completed**
Percent of initial denials are reversed by CMCs	**RESPONSE**: CMCs do not reverse cases; they provide medical opinions as evidence to the claims examiners.		**Completed**
Cost details (1) medical care (2) "wage replacement" (3) program adninistration	**RESPONSE**: The program will provide (1) website stats on medical care (listed and updated regularly on the program website); (2) wage loss stats (this is not wage replacement but lump sum compensation); (3) OMB information, as discussed above.	Website provided at meeting. OMB Budget Justification: https://www.dol.gov/sites/default/files/documents/general/budget/2016/CBJ-2016-V2-06.pdf;	**Completed**

Subcommittee Request - Part B Lung: 6/29/16	Program Response	Provided:	Completed?
Subcommittee members should look at the spreadsheet of data and see what summary information and/or additional fields of data they think would be useful, and send it to Dr. Dement in the next week	We are looking at Dr. Dement's follow-up request. We will add columns for whether there was a CMC or IH, but the Board should note that for CMC's, if there was one who worked on the case, it does not mean it was for anything related to the original acceptance or denial (it could've been for impairment). We cannot provide job titles as that is not captured in the system. We will add a column for denial and reasons for denial.	answer in email 8-12-16	**Complete.**
Request a set of claims for background exploratory review of (research into) the process: the RD and FD, and the CMC report if there was one, for: (1) 20 CBD cases (at least 10 denied); (2) 20 beryllium sensitivity cases (at least 10 denied); (3) 10 silicosis cases (some accpeted some denied)	We can provided the board with a CMC report but only if there is one. The Board should note that we do rely on other medical evidence in the case file when we issue decisions, and that we therefore do not go to a CMC at all in many cases. *Question: what is the purpose of requesting the RD, since it is not a final document in a case file? We will provide if needed, but are asking for clarification.* (1) We can randomly identify 10 cases that had CBD as an approved condition within a period of time (36 months). We can also randomly identify 10 cases that had CBD listed as a claimed condition which was subsequently denied within a period of time. (2) We can randomly identify 10 cases that had beryllium sensitivity as an approved condition within a period of time (36 months). We can also randomly identify 10 cases that had beryllium sensitivity listed as a claimed condition which was subsequently denied within a period of time. (3) We can randomly identify 5 cases that had silicosis as an approved condition within a period of time (36 months). We can also randomly identify 5 cases that had silicosis listed as a claimed condition which was subsequently denied within a period of time.	answer in email 8-12-16	**Complete.** On second nonreleasable disc
How many CMCs are in the system that review part B lung cases or most of them ?	There is no way to identify in the system whether CMCs review Part B lung cases or any other type of case. We will provide the reasons for referral to CMC, but we cannot distinguish between Part B and Part E as they are not captured that way.	answer in email 8-12-16	**Complete.** The reasons for referral are in PM Section 2-800.10

What is the vetting process used by QTC to add CMCs that review part B lung cases to the list? What do they need to show to establish qualification in a specialty? What training on the Part B lung program do they get?	Please have the Board refer to the SOW provided, as this is a contractual question.	**answer in email 8-12-16**	**Complete**
What is the percentage of (cases decided) claims submitted under the pre-1993 criteria as opposed to the post-1993 criteria in the past 3 years ? How is this usually decided?	There is no way to differentiate in the system between whether a decision in a case was predicated on pre or post 1993 criteria. The Procedure Manual (and the regulations) includes guidance for when a pre or post 1993 criteria is to be applied. It generally depends on when the employee was tested for, diagnosed with, and/or treated for a chronic respiratory disorder. Please see Chapter 2-1000, Eligibility Criteria for Non-Cancerous Conditions: https://www.dol.gov/owcp/energy/regs/compliance/PolicyandProcedures/proceduremanualhtml/unifiedpm/Unifiedpm_part2/Chapter2-1000EligibilityCriteria.htm	**answer in email 8-12-16**	**Complete**
For the last two years: on CBD cases, what are the credentials of the CMCs used? (this may be evident from #2 responses) would combine with 4. Only want CMC info related to Part B.	CMCs are required to have appropriate credentials, as required by the contract, please have the Board refer to the SOW for this answer.	**answer in email 8-12-16**	**Complete**
For sarcoidosis (looking at possible misdiagnoses) under Part E: request the last 15 cases claiming sarcoidosis, at least 10 denied: RD, FD, CMC report (could add to #38 above. (would omit looking at possible misdiagnoses)	We will randomly identify 5 cases that had sarcoidosis as an approved condition within a period of time (36 months). We can also randomly identify 10 cases that had sarcoidosis listed as a claimed condition which was subsequently denied within a period of time.	**answer in email 8-12-16**	**Complete.** On second nonreleasable disc
Request to see 10 claims for any interstitial lung disease (or pneumoconiosis?) and beryllium sensitivity shown (+BeLPT) (5 accepted and 5 denied if possible): RD, FD, CMC report (could add to #2.)	We will randomly identify 5 cases that had pneumoconiosis as an approved condition, and 5 cases as an approved condition within a period of time (36 months). We can also randomly identify 5 cases that had pneumoconiosis and 5 cases that had beryllium sensitivity listed as a claimed condition which was subsequently denied within a period of time (36 months). We cannot pull specific tests from our database.	**answer in email 8-12-16**	**Complete.** On second nonreleasable disc

What is the reason for the issue identified by the program about a disparity between diagnostic facilities? The subcommittee understands there are two facilities used, National Jewish and ORISE. Is the program seeing differences in a large number of cases?	We don't know of a disparity, as our system doesn't and isn't intended to track results from facilities. The mention of the two facilities was intended to indicate that there are a limited number of facilities that we ***regularly*** see conducting certain tests. The program will work with ANY facility that is authorized to conduct medical testing and doesn't track the results from any of the facilities, but we would like to see more facilities, in order to better support the geographic constraints of our claimant population and if the Board could assist with that, it would be appreciated.	**answer in email 8-12-16**	**Complete**

Subcommittee Request - SEM: 7-11-16	**Program Response**	**Provided:**	**Completed?**
Need data on claims by specific ICD codes, with other columns to include, at a minimum: site, whether claim was accepted or denied, and a reason for denial. We could work either with a code if reason for denial was assigned a code, or with text describing the reason.The Subcommittee would then review and request a sample of claim.	**RESPONSE:** Discussion with Dr. Welch and Dr. Markowitz on 8-3-16. DEEOIC will create a smaller data set for this request. Check in on August 25.	**call with Dr. Welch on 8-3-16**	**Complete.** On Second nonreleasable disc.
We would like access to the SEM database used by the claims examiners, since we understand that it differs from the database available to the public.	**RESPONSE:** Need DOE's permission to give them access. DOE insists that access be given only to feds with a PIV card, which requires an FBI background check.	**call with Dr. Welch on 8-3-16** Explain - not so much difference between public and proprietary SEM; Dr. Welch says do not need access for entire subcommittee; maybe Mark Griffon?	**Completed.** Possibly get Mark Griffon access.
We would like to review the written information and other training materials used to train staff of the resource centers how to assist the worker in completing the OHQ. Is there a script? We would like to understand the QA process for the OHQ - is some subset reviewed to ensure that they are being completed correctly?	**RESPONSE:** the OHQ is undergoing a revision. The board will be asked for their input after the DO input is incorporated.	**call with Dr. Welch on 8-3-16** * we should provide the OHQ info given to the IH & CMC subcommittee, to this committee also *	**Complete.**
We would like to see all written sources of guidance and procedures for claims examiners, IHs, and CMCs	**RESPONSE:** For CMCs, that is up to the contractor; For IHs, this materials is not created yet; for CEs, the primary source is the PM which is posted online	**call with Dr. Welch on 8-3-16**	**Complete.** IH guidance provided by email.
We understand DOL has a small number of presumptions that are used in claim adjudication. We would like to look at case examples where these presumptions were used.	**RESPONSE:** resent the program's list of Bulletins, Circulars, etc., relevant to each topic area.	**call with Dr. Welch on 8-3-16** Cases?	**Complete.** Ask committee to use the cases provided for Part B requests
For the October meeting, we would like a report from DOL how they have responded to the IOM report on SEM, and a description of the work plan for implementing the IOM recommendations	**RESPONSE:** the program is working on a draft of their IOM responses.	**call with Dr. Welch on 8-3-16**	**Complete.**

We would like background information from DOL about development of the 1995 memo	**RESPONSE**: For the most part, the February 2015 memo is our explanation for how we developed the circular (15-06) on this issue. See the link here: https://www.dol.gov/owcp/energy/regs/compliance/PolicyandProcedures/ExposureLevels_Memo.pdf As to why we created the distinction between pre-1995 and post-1995 exposures, we thought this would allow us to cut out the IH referrals on certain cases, which at that time were slowing down the process. This didn't mean that the cases would not undergo a medical review, but at least we could make an assumption that for cases in which the employee worked only after 1995, the exposures would have been within regulatory standards and guidelines. We could then send that statement directly to the treating physician for an opinion on causation.	**call with Dr. Welch on 8-3-16**	**Complete**. Email of 9-20-16

Subcommittee Request -Weighing Med Evid: 7/12/16	Program Response	Provided:	Completed?
Discussing PM "Sources of Medical Evidence": "Consensus documents from learned bodies" – is it the CEs responsibility to gather these? Or the CMCs responsibility?	(PM2-0800.2) We are not clear where this phrase "consensus documents from learned bodies" comes from in the PM, but it is ultimately the claimants' burden of proof to establish their cases; however the claims examiners are directed to obtain as much information as possible from many resources to assist in this task. Initial medical evidence of a condition is typically submitted by the claimant/treating physician, at which time the CEs will request additional information (if necessary) either directly from the claimant or from the treating physician (if there is one). If the information submitted by the claimant is sufficient to establish a diagnosis and there is evidence that the employee worked at a covered site, but there is additional evidence lacking (e.g. detailed exposure information, medical opinion on causation), then the CE may refer the case to a CMC, Industrial Hygienist or the Toxicologist. Any information submitted to the CMC, medical director, IH or Toxicologist's review is gathered and submitted by the CE.	narrative	**Completed - answered.**
Discussing PM "Types of Medical Evidence": Does all of the medical evidence get to the CMCs? For example, would a claimant's submitted symptom diary get to a CMC?	Only medical evidence determined to be relevant to the questions being asked of the CMC is typically included. In some cases, that would be ALL medical evidence, but not in every case.	narrative	**Completed - answered.**
Discussing PM "Developing Medical Evidence": Can the subcommittee get more background on the CE's duty to assist? Are there any training documents on this?	There is no legal "duty to assist" written into the law as there is in other statutes. However, given that the DEEOIC is dedicated to accepting cases whenever appropriate, DEEOIC employees are directed to assist every claimant in attaining or providing the information necessary to adjudicate the claim. This includes obtaining information from DOE and the other sources of employment verification listed in the PM. It also includes assisting in obtaining exposure and causation information whenever possible through the use of SEM and referrals to IHs or CMCs. If DEEOIC didn't use these tools, claimants would have less access to information necessary, which would likely result in more denials.	narrative	**Completed - answered.**
Discussing PM "Deficient Evidence": How do doctors evaluate effect on "historical" wages? Is this appropriate for physicians to do? Physicians normally evaluate impairment, not wage loss from such impairment.	(PM2-0800.5.b) The section of the PM to which you are referring is one example of the various topics that may require evaluation of medical evidence. In this example, for wage loss claims, the claimant must establish that the employee lost time from work as a result of the accepted condition. In order to be eligible for wage loss, the claimant must first establish when the employee first began losing time from work in order for the DEEOIC to establish a baseline average annual wage with which to compare any ongoing or later years of lost wages. It is sometimes difficult for a claimant to discern 1) when the employee first lost time from work as a result of the condition and/or 2) whether later years of lost time were related to the accepted condition. Oftentimes, claimants will state that the employee began losing wages decades ago, and the DEEOIC requires medical evidence to establish that those lost wages were related to the condition. That is what is meant by "effect of historical wages" in the PM.	narrative	**Completed - answered.**
Discussing PM "Telephone Request": Is there a paper trail for telephone requests to physicians?	PM 2-0800 5.c(1) states that the CE must document the call in the Energy Compensation System (ECS). This call then becomes a part of the claimant's permanent record.	narrative	**Completed - answered.**
Discussing PM "Unavailable Medical Records": What does the CE do if no records are available? Does this section of the PM add much to the process? What is its goal?	(PM2-0800.5.e) Sometimes claimants have reported that the employee's medical records have been destroyed due to record retention issues, closing of a facility, burning of a medical facility etc. In those cases when there is no medical evidence of a diagnosis or any treatment of the claimed condition but there is evidence that the employee was treated by a particular physician, the CE is directed to ask the physician to provide whatever evidence he/she may be able to provide based on his knowledge of the employee.	narrative	**Completed - answered.**

Discussing PM "Weighing Medical Evidence": (1) How are the CEs trained to weigh medical evidence? This is a difficult task for a non-medical person, how does it work in practice? Is it out of the scope of a CE's job to "weigh" medical evidence, and should only the CMCs be doing this?	(PM2-0800.6) The CEs are trained to evaluate all evidence that is submitted in a case file. This not only includes medical evidence, but any evidence, such as employment documentation. There are often complex employment issues related to whether an employee was on site at a covered part of a DOE facility – and various different documents are submitted to assist in making this determination. The CE must use critical analysis in these cases to determine what the facts are and how to apply the documentation. The CEs apply similar logic in weighing medical evidence. The PM is very specific as to what methods to apply when undergoing this analysis when it comes to medical evidence. Usually this situation occurs when there are conflicting medical reports in the case file (e.g. a treating physician and a CMC). The CEs are trained in conducting this analysis, and historically this has been through a hands-on approach (trainers evaluating specific cases and situations in a classroom setting). This analysis can often be straight-forward: for example, the treating physician provides a diagnosis and a statement that he/she believes that the condition is related to toxic substances in the work environment, without any detailed information regarding the type of exposure or any rationale as to how the physician came to this conclusion. In contrast, another treating physician, an occupational or some other sort of specialist, may submit a report with a detailed discussion of the employee's exposure, the specific toxins he/she was exposed to, the length of exposure, and an opinion, with rationale, as to whether the exposure caused, contributed to or aggravated the exposure. The PM advises that CEs should provide the historical, exposure information to the treating physician (based on a SOAF or specific questions) before moving on to a CMC. If the CE determines that the reports between a treating physician and a CMC (or second opinion physician) are too similar to be weighed one over the other, the CE is to refer the case to a referee medical examiner for a new opinion, as outlined in the PM.	narrative	**Completed - answered.**
(2) Can the subcommittee have a sort of "focus group" with 4 or 5 CEs to ask questions? Would the subcommittee members be allowed to sit down with a CE and go through claims as a CE would?	We would be happy to compile a group of individuals to discuss the step by step procedures.	narrative	**focus group? - see next meeting's action items list (Sept 13)**
(3) Are treating physicians compensated for their reports by DOL? How? Is payment whether accept or deny?	Treating physicians are paid for any examination and supporting reports that they submit as long as they are signed up as a Provider in the OWCP payment system and the treatment is for the accepted condition. Treating physicians do not accept or deny cases; this is completed by the DEEOIC.	narrative	**Completed - answered.**
(4) Could the subcommittee speak to treating physicians?	I don't have any objections to it, but we are not clear as to how we would do this logistically, since there are hundreds of physicians enrolled in the Program, we would have to get their permission and determine how to pick the physicians to talk to.	narrative	**Completed - answered.**
Discussing PM "Reviews by CMC": (1) The CE looks to be in tough spot for weighing medical evidence if they have no medical training. Does the CE ever confer with the CMC if there are questions? Can they get different physicians on a conference call or do they need to do "shuttle diplomacy" between everyone?	As indicated above in response to the weighing of medical evidence questions, the CEs are trained in weighing all medical evidence. The PM outlines the types of information to be reviewing. If follow-up or clarification is necessary, the CE does go back to the CMC for clarification. There are no conference calls between multiple physicians and the CE's.	narrative	**Completed - answered.**
(2) Request to look at (1) what materials the CMC gets with a referral, and (2) how they evaluate it, and (3) whether they interact with the Ces	I believe we provided a sample referral package to a CMC, but if not, we can provide a couple of examples. The CMC's evaluate the evidence using their expertise and professional judgment. CEs follow-up with the CMCs in writing, in order to ensure that the case file is documented appropriately.	narrative	**Completed - answered.**

(3) Can anyone (CEs, supervisors) question the validity of the CMC reports? Can the CEs question the treating physician's? Do the CEs actually "weigh" the CMC report or just accept it?	CMC reports are supposed to be evaluated like any other report and the CE may question any report submitted. As outlined in the PM, the CEs are expected to weigh the evidence submitted by the treating physician (and any other medical evidence in the file) with that the submitted by the CMC (if the opinions differ). CE's are NOT expected to simply accept the CMC's recommendations; however oftentimes the reason a case is referred to a CMC is that the CE was unable to obtain the necessary documentation from the treating physician. The CE's can and do question the treating physicians – the CEs are supposed to obtain the evidence from the treating physician first whenever possible, before any referral to a CMC. When there is a question or issue raised by the CMC that the treating physician may be able to answer, the CE is expected to question the treating physician. There are occasions when the CMC report is not used when a treating physician is able to sufficiently respond to a concern.	narrative	**Completed - answered.**
<u>The program asked for assistance on the following</u>:			
"Rationalization" – How complex a rationalization is considered adequate? Do not understand why a set of standardized triggers are necessary.	As indicated above, the CEs use the guidelines outlined in the PM to evaluate and weigh medical evidence. "Rationalized medical evidence" can be fairly straight forward; however when reviewing issues such as aggravation, contribution and causation, it is sometimes difficult to determine what level of rationalization should be required. The Program just thought if the Board had additional recommendations for the CEs to analyze the reports, that may be helpful, particularly in these more grey areas.	narrative	**Completed - answered.**
Development letters – can the program supply some types of letters/communications it would like to see improved? What is the background for the second bulleted request for assistance?	In our presentation on this subject, we requested assistance in the following: "Methodologies for improving physician responsiveness to data requests including review of development letters, outreach efforts, and provider communications." The background behind this is that we find it difficult to get the treating physicians to respond to detailed development letters. Oftentimes, we find that the physicians believe that if they have submitted a blanket statement of causation, without additional detail, that should be sufficient. We would like to be able to avoid going to CMCs and be able to rely on a claimant's treating physician, but we have difficulty obtaining the reports that would enable us to do so. Therefore, we were hoping that perhaps the Board could assist us by providing best practices for obtaining this type of information. We can supply the Board with some samples of development letters written to claimants/their physicians when the Program needs additional information (e.g. more discussion on the relationship between the claimant's actual established exposure and the accepted conditions) – they are often lengthy and physicians may not have the time or inclination to respond. Claimants also find it difficult to find physicians who are willing to enroll in the Program due to paperwork issues. Therefore, over the past several years, the Program has conducted regular outreach meetings throughout the country targeting physicians and other Providers, but we have had very low attendance from the physician community. We have a news blast email that goes out regularly that physicians or their assistants have subscribed to, and we are just now starting to host conference calls for physicians or their staff to call into. We are open to ideas from the Board as to how best to get physicians to enroll in the Program and to communicate with them about the requirements of the Program. We will provide some development letters to the Board.	narrative	**development letters: 10 - see next meeting's action items list (Sept 13)**

Training resources – what is out there on weighing medical evidence? The subcommittee would like to see the available materials in order to see how they could be improved.	The PM is the starting point of weighing medical evidence and oftentimes the District Offices will develop classroom training around that. As indicated above, the National Office has conducted hands-on training on this issue using examples from real cases (for both the District and FAB offices), but I don't believe we had a particular curriculum. If the Board is aware of guidance documents or training to assist in this effort, that would be helpful. We will provide some examples of training resources we have used in our offices.	narrative	**training resources?-** see next meeting's action items list (Sept 13)
"Contribution or aggravation" – this is a huge issue in the medical world, "aggravation" versus natural progression of a disease; how does the program handle it now? What does the program expect the sub-committee to address? This is a difficult task for physicians to tease out, not sure it's appropriate for a CE. What is the background on this request for assistance?	For Part E, the statute is very specific that exposure to toxic substances in the workplace must have been a "significant factor in causing, contributing to or aggravating" the claimed condition. Right now, the program relies on the medical opinions of the treating physicians or CMC physicians. As you indicate, it is a difficult task for physicians to tease out, but the role of the CE is to assess evidence that is submitted in support of a claim. If we had a guideline, or thresholds, or matrices that the physicians could follow with regard to what constitutes a "significant factor," and how to apply this complex statutory definition, that would enhance the ability of the physicians to respond and the CEs ability to apply the definition.	narrative	**Completed - answered.**
Could the program assign a CE to attend the subcommittee calls in the future?	We can definitely assign a Program person to attend the subcommittee calls – we are not sure whether it is appropriate for bargaining unit employees to fulfill this role, but we will work with the Board on it.	narrative	**Completed - answered.**
Request the Quarterly Management Reports (referred to in the CMC Statement of Work) for the last four quarters	Checking	narrative	*asking contractor*
What are the exposures/diseases that claimants are claiming often? The subcommittee thought that the frequency of diseases had been requested by someone else; add also frequency of exposure	We have no way to cull out the "frequency of exposure" from our database.	narrative	**Complete.** provided the list of 14 priority conditions, timeframe of early October

Subcommittee Request - IH & CMC: 7-18-16	Program Response	Provided:	Completed?
Do the claimants see and/or have input into the process of the CEs referring cases to the IH or CMC, and the IH/CMCs response; this includes how the CEs frame the questions to the IH/CMC. Do the claimants automatically get copies of the IH and CAC reports?	The type of claimant input in the referral process described in the question—which resembles the method used by opposing parties in litigation to agree upon the wording of questions that are then submitted to an outside, independent expert—are not appropriate for use in the non-adversarial claim adjudication process used by DEEOIC for several reasons. First, referrals to an IH or a CMC are only necessary when the claimant has not been able to respond to a CE request for the type of evidence necessary to support a claim. When this happens, the CE assists claimants by taking steps (through referrals to an IH and/or CMC) to obtain the necessary evidence for them. Second, referrals to an IH and/or a CMC are always predicated on a framework of factual findings, known as a "statement of accepted facts" or "SOAF," and the responsibility for preparing a SOAF is a central, fact-finding duty of the adjudicating agency, not claimants. And thirdly, it does not appear likely that there would be any benefit in requiring a CE to seek claimant input into the framing of questions to an IH or CMC, because with or without such input, those questions would still need to be phrased in a particular way so as to elicit a sufficient response that addresses the many specific factors that the statutory terms of EEOICPA require for a claimant to meet his or her burden of proof. The procedures for making these types of referrals, and framing questions to an IH or CMC, are clearly outlined in the procedure manual, which is posted on our web site. If a recommended decision is based, in part, on the opinion of an IH or CMC, these reports are automatically mailed to the claimants along with the recommended decisions.	answers given in email of 8-22-16	Completed
Request 30 case files, including 25 that have IH and/or CMC referrals (including referee referral where there is a difference in medical opinion) and 5 that did not include an IH or CMC referral, to review and discuss in working groups. We are mostly interested in cases that have been denied.	Recommendation: we pull the same cases that we are using for Dr. Redlich's request. We advise that rather than provide the entire case, which would be extremely time consuming, we provide them with the medical information from 3 years prior to a RD, the RD, any CMC or IH reports, and the FD.	answers given in email of 8-22-16	Completed
Would the cases have to be on paper and redacted? Could they subcommittee see them unredacted because they are SGEs? Could the subcommittee have electronic access to these cases?	They will be unredacted, on CD.	answers given in email of 8-22-16	Completed

Please highlight any internal guidance/training information given to CEs on the IH/CMC referral process that the board has already received and provide and additional information available. We are looking to get a better handle on how the CEs are trained and updated.	CMC – See PM 2-0800. 9-13: https://www.dol.gov/owcp/energy/regs/compliance/PolicyandProcedures/proceduremanualhtml/unifiedpm/Unifiedpm_part2/Chapter2-0800DevelopMedicalEvidence.htm IH Referrals – See PM 2-0700.12: https://www.dol.gov/owcp/energy/regs/compliance/PolicyandProcedures/proceduremanualhtml/unifiedpm/Unifiedpm_part2/Chapter2-0700ToxicSubstanceExposure.htm The program also notes that it now has an updated IH referral instruction sheet – attached (IH Referral Instructions). It was developed to assist in preparing IH referrals. It was distributed for use at the start of June.	**answers given in email of 8-22-16** Also attached IH referral instructions sheet (which is new). *Email from Doug P. on 8-15-16 had nonreleasable materials on IH training, that need to be on a disk*	**Completed.** On second nonreleasable disc
Request to see any internal guidance for administering the OHQ: is there a script? Or different scripts for different sites? Are there questions on types or exposures or levels of exposures?	See attached for the current form – "QHQ Form 1.doc"; The following attachments are drafts we've been working on to revise the form – "OWQ Completed Sample Form – John R. Doe and Sample OHQ – New Form Paducah Gaseous Diffusion Plant	**answers given in email of 8-22-16** Provided current OHQ form and DRAFT new forms	**Completed.** Provide new forms when finalized.
The program had asked for guidance on its Post 1995 Exposures memo and on the Asbestos memo, and the subcommittee will also include the hearing loss memo Post 1995.		**nothing requested of program**	**Completed**
The program has asked for help with presumptions. The subcommittee would like to get a sense of which diagnoses would be most helpful to look into, for developing presumptions – What are the most common diagnoses? What are some of the most common diagnoses? What are the program's priorities out of the universe of conditions?	We can provide the top 20 claimed conditions. Priorities are: 1. Cadmium, arsenic, TCE relationship to prostate cancer 2. Occupational toxins relation to Parkinson's Disease/Parkinsonism (we have some guidance on this, but Board review of what we have may be helpful) 3. Hearing loss from organic solvent exposure (as with #2, we have guidance but their review might be helpful) 4. Diabetes relationship to occupational toxic substances 5. Radiation connection to glioblastoma/meningioma 6. Non-Hodgkin's Lymphoma and trichloroethylene or benzene 7. Hyper/Hypo Thyroidism, Goiter/Nodules, and ionizing radiation 8. Breast Cancer many different exposures submitted 9. Immune system disorders – lupus, and others and many difference exposures submitted 10. Colorectal cancer and asbestos exposure and other exposures 11. Melanoma/Other Skin Cancers many exposures submitted 12. Kidney Cancer TCE, Benzene, Cadmium, asbestos 13. Bladder Cancer, many exposures submitted 14. Low level radiation relation to heart disease	**answers given in email of 8-22-16**	**Completed.**

The program has asked for help with communicating with physicians. The subcommittee agrees that there appear to be major communication issues and points out that some terms, such as "rationalize," "opine," and "suspicions" maybe challenging in this context. Are there current communication guidelines?	Only what is in the procedure manual.	**answers given in email of 8-22-16**	**Completed**
Does the program have staff physicians? What is their role? Is there a physician in each district office?	OWCP has a medical director who works with DEEOIC. His role is to answer questions from claims examiners on particularly complex medical issues when the medical evidence may be unclear to claims staff. No, there is not a physician in each DO, but sometimes CMC's are utilized to assist with some of these difficult medical questions.	**answers given in email of 8-22-16**	**Completed.**
The program asked about help with dealing with synergies. The subcommittee will attempt to identify sample resources.		**nothing requested of program**	**Completed**
How many referee opinions were given in the last year? Out of how many total opinions?	Zero. Is this out of total CMC opinions? Second Opinions? Please clarify.	**answers given in email of 8-22-16; numbers given in email beginning of Oct**	**Completed**
Followup questions from Dr. Sokas in email of 9-12-16:			
Would it be possible just to get one case from each of the 14 priority areas for claimed conditions (described earlier in this email stream)? Again, it's helpful to have the material as presented to and from the CMC, but also the final case determination, to see how that material was used.			**Complete** - provided on disc #3
We may already have these, but Carrie, would you please send George the guidance on PD and me the guidance on solvents?			**Complete** - provided via email with links

Subcommittee Request -Weighing Med Evid: 9/13/16 **Materials and Timing:**	**Program Response**	**Provided:**	**Completed?**
Development letters to physicians	*(Doug will get estimates from the people working on this – the searching needs to be done manually, there is no algorithm for searching for development letters)*	action items email	**Complete** - disc #3
Training materials relevant to weighing medical evidence	*(on a non-encrypted disc, probably next week)*	action items email	being prepared as PDFs for the website
Cases from the 14 identified Priority Areas	*(a few weeks, as each search needs its own algorithm and some are inexact) – this is the second subcommittee to request this, the IH & CMC subcommittee already requested, and Doug has started on this*	action items email	**Complete** - disc #3
Timing/specifics of the "focus group" request	*(to be discussed following subcommittee/working group review of the previous materials)*	action items amail	discuss at Board meeting and following
Questions for program:			
If a claim is not accepted, there is no mechanism for compensating physicians through OWCP. What about causation opinions in accepted cases, and/or other services done for program claimants by physicians (in addition to treating) – how are these paid? Is there an ICD-10/CPT/E&M code for this? If not what would/could be done?	In accepted cases, we will pay for medical services done for the accepted condition retroactive to the date of filing. The physician or provider simply needs to be enrolled.	email from Rachel	**Complete** email of 9-22-16
(for Carrie and Tony) Guidance on subcommittee/working group communication and meetings given the confidential materials	email sent 9-21-16	email from Carrie	**Complete** email of 9-21-16 ("Privacy Requirements re: Nonreleasable Information Given on Discs")

Subcommittee Request - SEM 9/20/16	Program Response	Provided:	Completed?
***Dr. Welch prepared action itmes list from meeting 10-6-16:**	**email to program 10-7-16:**		
(1) Committee agreed with Dr. Welch's recommendations to DOL for ways to respond to the IOM report; see document prepared for the call. Dr. Welch will prepare a proposal for the Board to review at the October meeting. The recommendation is to have an expert committee that determines what other sources DEEOIC should routinely use to add causation links to the SEM. It may be that this committee could be a subset of the Board, and the Board could consider a pilot of this approach to assess how much work it would be. Committee had a question for DEEOIC about the response memo. How were work processes and mixtures added? Was there any expert input, peer review of this?			need response
(2) Committee discussed the kinds of claim files we would like to review in detail, after discussing the limitations we may have in requesting data. We agreed that denials will give us a good idea of the problems the Board should address. Denials are coded by broad categories, and it appears that claims denied because of a negative causation request may be the ones to review first. Dr. Dement has reviewed claims data for the Part B lung disease subcommittee, and found that in part E lung disease claims 50% of the denials were due to a negative causation result. We want to assess the role of the SEM and the OHQ in claims adjudication, but there may be no clear way to identify cases where SEM or OHQ was key. It was pointed out that there are many sites without a SEM, so the committee agreed it was important to review claims with denials from these sites in particular. Since we are interested in the use of the new presumption regarding COPD, which was put in place in February of 2015, we need to review some claims filed after that time. Even though a number of claims first filed in 2015 and 2016 do not yet have a final determination, the committee thought reviewing denials from time frame after presumption was announced would be valuable. Based on this discussion we will ask for 25 files for COPD claims that were denied due to a negative causation result, with as many as possible being claims filed after March 1, 2015.			need cases
We will also request a report on all claims using the broad categories of pulmonary disease, heart disease, etc that includes same data fields provided for the Part B lung disease committee.			need report

(3) OHQ and IH role in exposure assessment: Committee discussed importance of the OHQ and the limitations of both the current version and the way it is administered. We agreed that the Resource Centers should hire former workers from each site to administer the OHQs, and develop a process that includes continue quality improvement and refinement of the OHQ based on information for interviews. The program can be modeled on the BTMed approach which has been used successfully for many years. The committee agreed it is essential that the IH consultants reviewing claims be authorized to talk to the claimant about his/her work history if more information is needed to provide an informed opinion. We would also recommend the claimant be allowed to have another person as other support present, to help the claimant if his memory is spotty. These workers didn't know about a lot of exposures even when they were occurring, and have forgotten much of what they knew, so although this interview can improve/enhance exposure assessment it will necessarily be imperfect. The committee also concluded that if this IH consultation and the improvement in the OHQ are implemented well, the circular from DEEOIC about exposures before and after 1995 will become irrelevant since exposures for each worker will be assessed, rather than relying on assumptions.

nothing needed

Subcommittee Request - Part B Lung 9/21/16	Program Response	Provided:	Completed?
*no information requested from this meeting - subcommittee members to be assigned cases for reading and preparing standard templates to be given by Dr. Redlich		narratives, phone call clarification	all completed
*** Dr. Dement sent three questions for the program**	***October 5, 2016 call with Dr. Dement, Dr. Markowitz, DEEOIC to discuss Dr. Dement's questions:**		
I have been working to summarize data in the file 'US 10744 – Advisory Board Subcommittee Data Request – Modify' provided by DOL on 9/8/2016. I need some help from DOL to interpret some data fields that seem to contradict data found in other fields. Here are my questions:	**responses from call:**		
1. For Part B data there are data fields entitled 'Med Conditions Approved' and 'Med Conditions Denied'. I have restricted the data for some analyses to cases which have only a single entry for the field 'Med Conditions Filed' (e.g. BD, BS, CS). I am finding many cases where the condition is listed in both the 'Med Conditions Approved' and 'Med Conditions Denied'. How can this happen and how do I interpret this condition with regard to approval or denial of the case condition?	There are many case events that are entered into ECS. Cases have a B component and an E component. The acceptances/denials are not tied to conditions in the system.		
2. In addition to the fields 'Med Conditions Approved' and 'Med Conditions Denied' we have separate fields for approval or denial of for the 7 conditions (e.g. CBD Approved, BS Approved, CS Approved, etc.). These fields are coded Y/N. Does this field provide information with regard to final adjudication of the case and condition? I am finding the results in these fields often contradict data in the 'Med Conditions Approved' and 'Med Conditions Denied' fields. Which of these data should be used to determine final approval or denial?	Most cases have a B component and an E component, and have more than one claimed condition. Some have only one condition. DEEOIC will check the requirements document for this report to see if one Part is trumping the other Part in terms of dates shown. Typicaly the program assumes that if there is an acceptance it is the last decision, as there would be mo more action on that condition.		
3. Fields are provided for Part B calendar year of first approval or denial ('First Approval CY' and 'First Denial CY'). I have restricted some analyses to single listed values in the field 'Med Conditions Filed' (e.g. CS). I am finding many cases where the field 'CS_Approved' is not blank (i.e. values are Y or N) with no data for 'First Approval CY' or 'First Denial CY'. When I look at the 'CS_Approved' field for those missing 'First Approval CY' and 'First Denial CY' I find that are all CS_Approved=N (denied). Why are the data for calendar approval or denial missing only for cases not approved? For example, among cases with CS only filed, I find 487 cases which were not approved for CS (CS_Approved=N) and are missing calendar year data?	Make sure to look in the Part B and the Part E sections for claimed conditions and case actions. The Parts influence how the report is put together, depending on the logic of the requirements document.		
	Rachel Leiton has a couple of key points she would like to relay that may be important in the review of the cases: In general, for Part B cases, we do not look at exposure under Part B because it is presumed; however, the definitions under Part B for both CBD and chronic silicosis are very strict.		

- Our biggest struggle with Part B for CBD is the actual definitions themselves using pre-1993 and post-1993 criteria, not whether there was exposure. The definitions under the statute for "established chronic beryllium disease" can be interpreted differently by different physicians, and we need to apply these standards to whether or not we can accept a claim for CBD under Part B (not whether someone has simply been diagnosed with CBD). For example:
  - After 1993, the lung biopsy must show granulomas or a lymphocytic process "consistent with" CBD, the CT scan must show changes "consistent with" CBD, or a PFT must show pulmonary deficits "consistent with" CBD. It is this language "consistent with" that sometimes causes problems;
  - Pre-1993, there must be "characteristic" chest radiographic abnormalities, lung pathology "consistent with" CBD, clinical course "consistent with" CBD. These are 3 of the 5 criteria and we only need to establish 3 to meet the test, but the other 2 are "restrictive or obstructive lung physiology testing or diffusing lung capacity defect, and immunologic tests showing beryllium sensitivity (skin patch test or beryllium blood test preferred)." Our issues with these definitions are again the terms "consistent with" and "characteristic of."
  - We rely on medical evidence from physicians to provide us with evidence that meet these criteria, and those opinions can vary; many physicians may not be familiar with what is "consistent with or characteristic of" CBD.
  - In contrast, since there was no mandatory statutory definition provided for CBD under Part E, we are able to accept those cases if there is an abnormal BeLPT (beryllium sensitivity) and a diagnosis of CBD from a physician, so it is much less complicated. So it is possible for a claim to be accepted for CBD under Part E but not under Part B, but if a case is accepted for CBD under Part B, it is automatically accepted for CBD under Part E.
- Under Part B, chronic silicosis may ONLY be accepted under the following circumstances (per the statute at 7384r) – therefore acceptance for this condition under Part B is very limited:
  - (c) EXPOSURE TO SILICA IN THE PERFORMANCE OF DUTY—A covered employee shall, in the absence of substantial evidence to the contrary, be determined to have been exposed to silica in the performance of duty for the purposes of the compensation program if, and only if, the employee was present for a number of work days aggregating at least 250 work days during the mining of tunnels at a Department of Energy facility located in Nevada or Alaska for tests or experiments related to an atomic weapon.

- (d) COVERED EMPLOYEE WITH CHRONIC SILICOSIS—For purposes of this subchapter, the term "covered employee with chronic silicosis" means a Department of Energy employee, or a Department of Energy contractor employee, with chronic silicosis who was exposed to silica in the performance of duty as determined under subsection (c).
- (e) CHRONIC SILICOSIS—For purposes of this subchapter, the term "chronic silicosis" means a non- malignant lung disease if—
  - (1) the initial occupational exposure to silica dust preceded the onset of silicosis by at least 10 years; and
  - (2) a written diagnosis of silicosis is made by a medical doctor and is accompanied by—
    - (A) a chest radiograph, interpreted by an individual certified by the National Institute for Occupational Safety and Health as a B reader, classifying the existence of pneumoconiosis of category 1/0 or higher;
    - (B) results from a computer assisted tomograph or other imaging technique that are consistent with silicosis; or
      (C) lung biopsy findings consistent with silicosis.

Any claim that is accepted under Part B is automatically accepted under Part E (as long as the Part E employment criteria are met).

Sarcoidosis, in and of itself, is NOT a covered condition under Part B; however, there have been circumstances in which the physician misdiagnosed sarcoidosis when it should have been CBD. This often occurred before there was much information about CBD. As a result, we realized that perhaps we could accept cases filed for sarcoidosis under Part B as cases for CBD under certain circumstances. So when we accept or deny a claim filed for sarcoidosis under Part B, we are really adjudicating them for CBD. This is the ONLY circumstance in which we need to look toward exposure for a Part B condition. We can look at sarcoidosis separately under Part E. The Procedure Manual at 2-1000.10, outlines the circumstances under which we could accept cases for CBD filed as sarcoidosis:

o Presumption of CBD, Diagnosis of Sarcoidosis, and History of Beryllium Exposure. Sarcoidosis is a disease that represents as inflammation of cells that form into nodules or granulomas. Sarcoidosis can occur in different organ systems. Under Part B, the DEEOIC recognizes that a diagnosis of pulmonary sarcoidosis, especially in cases with pre-1993 diagnosis dates, could represent a misdiagnosis for CBD. As such, a diagnosis of pulmonary sarcoidosis is not medically appropriate under Part B if there is a documented history of beryllium exposure. In those situations, a diagnosis of sarcoidosis is evaluated as a claim for beryllium sensitivity and/or CBD. Under Part E, if there is a diagnosis of pulmonary sarcoidosis, but no affirmative evidence in the form of a positive BeLPT or BeLTT exists, the CE adjudicates the condition as sarcoidosis, not CBD. Part B of the EEOICPA specifies diagnostic criteria necessary to qualify for compensation. As such, in the case of a diagnosed pulmonary sarcoidosis being treated as beryllium sensitivity or CBD, it is necessary for the CE to obtain the evidence satisfying pre-1993 or post-1993 CBD criteria enumerated under the Act.

There was some question about whether we could break out the cases by line item for each condition, showing which condition was denied and for what reason. Unfortunately, we are unable to break out our data that way and that is why we provided the data the way that we did. They discussed looking for cases in which only one condition was claimed and breaking that out, and that should work.

There was some discussion of the EECAP statistics. We've had several discussions with Ms. Jerison about the data that she puts up on her web site, and as a result, about a year and a half ago, we began sending her monthly data reports. A sample from August is attached. I'm not sure what other EECAP statistics they were looking at, but this is what we provide.

Dr. Redlich followup question on RECA: from email 9-27-2016:

Uranium miners / silicosis – seems case needs to first be approved by RECA (Radiation Exposure Compensation Act) to be considered. Attached some info on RECA if needed. RECA has strict eligibility criteria. (I can send if interested). Could use clarification re miners and also criteria diagnose silicosis.

Rachel's response:

With regard to RECA, DOL has no part in whether a claimant is eligible for RECA; however, if DOJ accepts a claim under RECA Section 5 (NOT RECA Section 4 – downwinders) we can pay an additional $50,000 plus medical benefits for the condition(s) already accepted by DOJ. If a claim is accepted under Part B, it is automatically accepted under Part E. For more information on our RECA procedures, see the PM Chapter here:
https://www.dol.gov/owcp/energy/regs/compliance/PolicyandProcedures/proceduremanualhtml/unifiedpm/Unifiedpm_part2/Chapter2-1100EligibilityRequirements.htm

Dr. Dement followup - sent a new data file

following discussion with Doug Pennington 10-14-16

sent 10-14-16